STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001143	A. BUILDING: _____ B. WING _____	C 06/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTAGE MANOR HEALTH CARE FACILITY	3016 PORTAGE AVE SOUTH BEND, IN 46628

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This survey was for the Investigation of Complaint IN00172462. Complaint IN00172462 - Substantiated. No deficiencies related to the allegation are cited. Survey dates: June 8-9, 2015 Facility number: 001143 Provider number: 001143 AIM number: N/A Census bed type: Residential: 121 Total: 121 Census payor type: Other: 121 Total: 121 Sample: 3 Portage Manor Health Care Facility found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00172462.	R 000		